



## Comprehensive History and Physical Examinations 2026

### History and Physical Examination Definition

**Intent and Background:** The CPME 320, *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies* requires that podiatry residents demonstrate competency in performing comprehensive history and physical (H&P or CHPE) examinations across diverse clinical settings and patient populations. Comprehensive H&Ps form the foundation of clinical reasoning and diagnostic acumen, requiring residents to integrate patient history, physical examination findings, and ancillary studies to develop appropriate diagnosis and treatment plans. These experiences must represent a variety of clinical scenarios and demonstrate the resident's evolving clinical judgment and decision-making processes.

A comprehensive H&P differs substantially from a problem-focused H&P. The resident must understand when each type of documentation is appropriate and be able to execute comprehensive evaluations that demonstrate complete clinical assessment skills.

### Minimum Requirements and Documentation Standards

#### I. CPME 320 requirements:

- **Minimum of 50 comprehensive H&Ps are required** during residency training.
  - Admission, preoperative, and outpatient H&Ps may be used as acceptable forms of a comprehensive H&P.
  - A problem-focused history and physical examination does NOT fulfill this requirement
- **Minimum of 25 comprehensive H&Ps** must be performed during non-podiatric rotations.
- Residents must demonstrate the ability to use information obtained from history, physical examination, and ancillary studies to arrive at an appropriate diagnosis and treatment plan
- Documentation of the assessment and treatment plan must reflect adequate investigation, observation, and judgment of the original complaint fulfilling the requirements of a comprehensive H&P.

- II. **It is recommended** that residents prioritize obtaining comprehensive H&Ps in their medical and surgical specialty rotations and are encouraged to log all comprehensive H&P experiences for credentialing and professional development purposes.

#### III. Supervision and Co-signature Requirements

- Comprehensive H&Ps logged as resident patient experiences must be supervised experiences.
- Documentation should be performed by the resident and must be co-signed/attested by the supervising attending MD/DO/DPM/APP. The resident's participation in the H+P must be accurately documented in the rare event that the resident does not document the H&P.

## **Components of a Comprehensive History and Physical Examination**

### **1. CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS (HPI)**

**Includes most but not necessarily all of the following:**

- Detailed chronology of patient's current complaint(s)
- Onset, duration, severity, and progression of symptoms
- Associated symptoms and constitutional findings
- Impact on activities of daily living and functional status

### **2. PAST MEDICAL HISTORY**

**Includes most but not necessarily all of the following:**

- Comprehensive listing of all significant medical conditions
- Past surgical history
- Medication history (current and recent)
- Allergies (drug, food, environmental) with type of reaction documented
- Immunization status when pertinent to the chief complaint
- Family history of significant conditions
- Social history (occupation, living situation, substance use, sexual history as appropriate)

### **3. REVIEW OF SYSTEMS**

**Includes most but not necessarily all of the following:**

- Comprehensive review across major organ systems
- Documentation of positive and pertinent negative findings
- Not limited to system(s) related to chief complaint

### **4. PHYSICAL EXAMINATION**

**Includes most but not necessarily all of the following:**

- Vital signs
- Mental status and general appearance
- Systematic head-to-toe examination appropriate to patient age and clinical scenario:
  - HEENT
  - Neurologic
  - Cardiovascular
  - Pulmonary
  - Abdominal
  - Dermatologic / Integument
  - Musculoskeletal
- Documentation of findings, not limited to affected area(s)
- Abnormal findings described in detail; pertinent negatives documented

## 5. LABS & IMAGING

**Includes most but not necessarily all of the following:**

- Labs and imaging should be ordered, as indicated by the HPI. .
- Laboratory values and imaging results should be included within the Comprehensive H&P. If not available at the time of documentation, the statement “pending” should be present to indicate the thought process and intention

## 6. ASSESSMENT

**Includes most but not necessarily all of the following:**

- Synthesis of history and physical examination findings
- Differential diagnosis when appropriate
- Clinical impression and interpretation of findings
- Statement of clinical reasoning connecting examination to assessment

## 7. PLAN

**Includes most but not necessarily all of the following:**

- Specific diagnostic testing ordered, preferably with reasoning
- Treatment recommendations, preferably with reasoning
- Patient education and counseling
- Follow-up plan with specific timelines
- Referrals or consultations recommended, when needed
- Medication prescriptions (if applicable)

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**Document prepared for:** Podiatry Residency Directors and Residents

**Reference:** [CPME 320](#), *Standards and Requirements for Approval of Podiatric Medicine and Surgery Residencies*

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